IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
KAREN R. VASTERLING – PROGRAM MANAGER
CERTIFIED FAMILY HOME PROGRAM
1070 Hiline Road, Suite 370
Pocatello, ID 83201
PHONE (208) 239-6273
FAX (208) 239-6269
www.cfh.dhw.idaho.gov

CERTIFIED FAMILY HOME ALTERNATE CAREGIVER TRAINING FORM

www.cfh.dhw.idaho.gov

CFH Provider _____ Phone_____

Address _____

Alternate Caregiver _____ Phone _____

Address _____

Participant Name(s) _____

Date(s) Alternate Care to be provided: from _____ to _____

___ I have been supplied relevant resident information:
Emergency Numbers, Primary Physician(s), Family Contacts, Affiliated Agency, Program Coordinator, Target Service Coordinator, DDA, and all scheduled appointments.
*Comments*_____

_____

_____

___ I am aware of the resident's needs as outlined in the Service Plan and agree to ensure that these needs are met.
*Comments*_____

_____

_____

____ I am aware of all daily and PRN medications, treatments, special diets, physician orders, current health, and behavioral status. I have been provided with ____ day(s) medications in blister pack, mediset, original pharmacy-dispensed container, or original over-the-counter container for alternate care.

*Comments*_____

_____

_____

____ I am aware of all skills training programs, formal and informal, and data to be taken. All programs are to be continued while resident is in my care (if applicable).

*Comments*_____

_____

_____

I, the Alternate Caregiver, have been trained to provide alternate care and services for _____ _____and have received all records required to do so. I have the necessary skills and training to provide the care this resident needs. All agreements made between the CFH Provider and the resident will remain in effect while I am providing care. I agree to maintain documentation of the services I provide and will return the resident's records to the Primary Provider when alternate care is completed except a copy of NSA or ISP, progress notes and incidents/accidents log which will be kept in my file.

Alternate Caregiver Date

The following records have been provided the Alternate Caregiver to ensure continuity of services while in alternate care:

- ☐ Admission Agreement
- ☐ Resident Records Form
- ☐ Medication sheet & medications
- ☐ Inventory Sheet of Items taken to Alternate Care
- ☐ Resident Rights Policy & Agreement
- ☐ Medication Authorization
- ☐ Equipment
- ☐ Copies of Service Plan (ISP or NSA)

Other _____

Certified Family Home Provider Date